STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	001150	A. BUILDING _____ B. WING _____	12/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA OF THE WOODS	5610 NOLL AVE FORT WAYNE, IN 46806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: December 26 & 27, 2012 Facility number: 001150 Provider number: 001150 AIM number: N/A Survey team: Sue Brooker RD TC Census bed type: Residential: 10 NCC: 3 Total: 13 Census payor type Medicaid: 7 Other: 6 Total: 13 Sample: 7 Villa of the Woods was found to be in compliance with 410 IAC 16.2 in regard to the State Licensure Survey. Quality review completed 12/27/12 by Randy Fry RN.	R 000		